

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
03162												
03145												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First <i>ELIZABETH</i>		Middle <i>ANTAL</i>		Last <i>ANTAL</i>		2a. DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>68</i>		2b. HOUR <i>1A</i> M	
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Mar. 7, 1905</i>			6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Hungary</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>TAILOT</i>			
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Caroline</i>			13c. CITY OR TOWN <i>Henderson</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>None</i>	
14. FATHER'S NAME First <i>Michael</i> Middle <i>Toth</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Nani</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Louis Antal Henderson, Maryland</i>					Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypokalemia, cause not determined</i> <i>279X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>2867 Diabetes mellitus</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert W. Trever</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>2-27-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>			22e. ADDRESS <i>Easton, Maryland</i>			22f. DATE <i>2/27/68</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-29-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>			23d. LOCATION (City or Town) (County) (State) <i>Greensboro, Maryland</i>			
24. FUNERAL DIRECTOR <i>J. E. Bouclair</i>			ADDRESS <i>Greensboro, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>MAK 1 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

63182

UNITED STATES DEPARTMENT OF JUSTICE

1963

Female

Marriage

June

July and

Michael John

no

none

John Michael Johnson, Maryland

1/21/63

U.S. District Court, District of Columbia

Washington, D.C.

John Michael Johnson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03163

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03145

1. DECEASED-NAME (Type or print) <b>FANNIE</b> First Middle Last			2a. DATE OF DEATH 2 Month 14 Day Year 68			2b. HOUR 2:30 P.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH JAN 13, 1887		6. AGE (In years last birthday) 81 YRS.		
7a. BIRTHPLACE (State or foreign country) WSP		7b. CITIZEN OF WHAT COUNTRY? WSP		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TA/boT		
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp. for			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SUPERVISOR		
12b. KIND OF BUSINESS OR INDUSTRY CLOTHING			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CAROLINE		13c. CITY OR TOWN DENTON	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
14. FATHER'S NAME JOHN First Middle Last			15. MOTHER'S MAIDEN NAME FRANCES First Middle Last JOSEPHHECK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT MISS HELEN SELIN DENTON, MD. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>337X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 31 hours.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCX								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>68</u> , to <u>2-19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Stephen P. Carney</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 2-20-68				
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney				22e. ADDRESS M.D. Easton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE FEB 22, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD.		
24. FUNERAL DIRECTOR <u>Virgil Morrison</u> ADDRESS Denton				25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		

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03165		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03146	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last MARY ELIZABETH Breeding			2a. DATE OF DEATH Month Day Year Feb. 1 1968		2b. HOUR 6:50 PM
3. SEX FEMALE	4. RACE WHITE		5. DATE OF BIRTH 9-12-91		6. AGE (In years last birthday) 76 YRS.
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH EASTON, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) at home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CAROLINE	13c. CITY OR TOWN DENTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last JAMES H. NICHOLS		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE PRICE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown NO		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS CESAR COALLA	
18. ADDRESS DENTON, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3378</u> (b) <u>Recent stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia due to chronic gastrointestinal bleeding 4 yrs</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>1 Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>31 Jan</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stephen O. Campbell</u>				22c. DATE SIGNED 2-2-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE FEB 04, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON	
23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD		24. FUNERAL DIRECTOR Charles Moore Denton Ind.			
25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03162

RECORD OF DEATH

03162

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03164										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03144											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																															
1. DECEASED-NAME (Type or Print) First Middle Last <b>Mary Nashold Bowman</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>2-21-68 19</b>										2b. HOUR <b>9P</b>											
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>8-16-1917</b>		6. AGE (In years last birthday) <b>50 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>2 21 1968</b>										2d. HOUR <b>930</b>									
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Caroline DOA Talbot</b>										Md.									
10. CITY OR TOWN OF DEATH <b>Easton</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Caroline Greensboro</b>				13c. CITY OR TOWN <b>Greensboro</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <b>So. Main</b>															
14. FATHER'S NAME First Middle Last <b>Harrison Nashold</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>Annie M. Hooper</b>																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>										16b. SOCIAL SECURITY NO. <b>Unknown</b>										17. INFORMANT <b>Heath Bowman Greensboro, Maryland</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4309</b> IMMEDIATE CAUSE (a) <b>Rupture of cerebral Arterial Aneurysm sec</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aneurysm of right Carotid artery just inside the skull</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> 75 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Was driving a car but loss of control of car not due driving Mishap</b>																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										22b. DATE SIGNED											
ACTUAL SIGNATURE <b>[Signature]</b>										M.D. <b>[Signature]</b>																					
EXAMINER'S NAME (Type) <b>Harold B. Plummer M.D.</b>										ADDRESS (Street, city, town, or county) <b>Reston Carolien Md</b>																					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>2-24-68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>					23d. LOCATION (City or Town) (County) (State) <b>Greensboro, Maryland</b>																
24. FUNERAL DIRECTOR <b>J. E. Bouleais</b>										ADDRESS <b>Greensboro, Md.</b>										25a. REC'D BY REGISTRAR DATE <b>FEB 27 1968</b>					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>						

05166

05166

WORLD EXHIBITION - 1904

1904

Henry Nashol Bowman

James W. Nashol Bowman

Virginia A. Nashol Bowman

Robert Nashol Bowman

Caroline Nashol Bowman

John Nashol Bowman

William Nashol Bowman

Elizabeth Nashol Bowman

Charles Nashol Bowman

Thomas Nashol Bowman

George Nashol Bowman

John Nashol Bowman

William Nashol Bowman

Charles Nashol Bowman

Thomas Nashol Bowman

George Nashol Bowman

John Nashol Bowman

William Nashol Bowman

05166

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03166

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03147

1. DECEASED-NAME (Type or print) <i>Robert Leon Brinsfield</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>26</i> Year <i>68</i>			2b. HOUR <i>5:30</i> P. M.			
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>6-25-21</i>		6. AGE (In years last birthday) <i>46</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>unk.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>unk.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>113 Park Street</i>	
14. FATHER'S NAME First <i>Herman M.</i> Middle <i>M.</i> Last <i>Brinsfield</i>			15. MOTHER'S MAIDEN NAME First <i>Inez</i> Middle <i>Jones</i> Last <i>Jones</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>219-07-3357</i>		17. INFORMANT Address <i>Mrs. Inez Brinsfield, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>680.1</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Complication of milk</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>690.1</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. C. H. Schmitt</i>		22c. DATE SIGNED <i>27 Feb 68</i>		22d. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmitt</i>		22e. ADDRESS <i>Coatons, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2/29/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Talbot, Md.</i>			
24. FUNERAL DIRECTOR <i>Ray D. Haverlin</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

5180

STATE OF TEXAS

38183

IN SENATE,  
January 15, 1903.

REPORT OF THE  
COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1902.

ALBUQUERQUE, N. M.

1903.

PRINTED BY THE

GOVERNMENT PRINTING OFFICE

WASHINGTON, D. C.

1903.

THE STATE OF TEXAS,  
COUNTY OF [ ]  
I, the undersigned, Clerk of the Senate,  
do hereby certify that the foregoing is a true and correct copy of the  
report of the Commissioner of the General Land Office for the year 1902,  
as the same appears from the records of the Senate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>Howard</b>						2a. DATE OF DEATH Month <b>2</b> - Day <b>10</b> - Year <b>68</b>			2b. HOUR <b>1 1/2</b> P.M.			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>MAY 20, 1883</b>			6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>4</b>		IF UNDER 24 HRS. HOURS <b>1</b> MIN. <b>15</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b>						
10. CITY OR TOWN OF DEATH <b>EASTON</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>				13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>HICKMAN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>Paul</b> Middle <b>CHARK</b> Last <b>CLARK</b>				15. MOTHER'S MAIDEN NAME First <b>SARA</b> Middle <b>JONES</b> Last <b>JONES</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. W. D. W. SMITH, SMYRNA, DEL.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONSOLIDATIVE RIGHT LUNG PNEUMONIA</b> <b>011.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>FAR ADVANCED PUL. TUBERCULOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNKN.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>0021</b>												
19a. DATE OF OPERATION <b>2-8-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TO ASSIST RESPIRATIONS AND REMOVE LUNG SECRETION</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>2-7</b> , 19 <b>68</b> , to <b>2-10</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>2-10</b> 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Richard Tyson</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-10-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>RICHARD TYSON</b>						22e. ADDRESS <b>221 GLENWOOD AVE. EASTON MD. - 21601</b>						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>FEB 13, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLYWOOD</b>			23d. LOCATION (City or Town) (County) (State) <b>HARRINGTON KENT DEL.</b>					
24. FUNERAL DIRECTOR <b>Virgil Momet San Denton</b>						25a. REC'D BY REGISTRAR <b>DATE FEB 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

MEDICAL CERTIFICATION

14180

UNITED STATES DEPARTMENT OF AGRICULTURE

1918

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1917

AND THE STATE OF TEXAS

IN RESPONSE TO A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

PASSED MAY 1, 1917

AND A RESOLUTION OF THE SENATE

PASSED MAY 1, 1917

AND A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

PASSED MAY 1, 1917

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AND A RESOLUTION OF THE SENATE

PASSED MAY 1, 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Kenneth Robert Colburn</i>						2a. DATE OF DEATH Month <i>B</i> Day <i>68</i> Year			2b. HOUR <i>5:15</i> M		
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>8/20/1921</i>		6. AGE (In years last birthday) <i>46</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.					
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL HOSPITAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>POLICEMAN</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>MARYLAND</i>			13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>420 S. HARRISON ST.</i>		
14. FATHER'S NAME First Middle Last <i>JOSEPH COLBURN</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>ETHEL GREENHAWK</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO. <i>219-07-0308</i>		17. INFORMANT Address <i>MRS. KENNETH COLBURN, EASTON, MD.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>2509</i> <i>Chemia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>260X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 13</i> 19 <i>68</i> , to <i>19</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 13</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. C. H. Schmitt</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>14 Feb 68</i>					
22d. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmitt</i>				22e. ADDRESS <i>Easton, Md. 21601</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>2/17/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OXFORD</i>		23d. LOCATION (City or Town) <i>OXFORD, MD</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Maurice E. Williams-Son</i>				ADDRESS <i>E. Easton, Md</i>		25a. REC'D BY REGISTRAR <i>FEB 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			

0316

0418

0418

0418

## CERTIFICATE OF DEATH

03169

03150

1. DECEASED-NAME (Type or print) <b>Roger Ross Dolby</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>68</b>			2b. HOUR <b>6:05</b> P.M.			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6/2/1904</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot</b> Md.			
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Dor.</b>		13c. CITY OR TOWN <b>HURLOCK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Broad St</b>	
14. FATHER'S NAME First <b>Hiram</b> Middle <b>J</b> Last <b>Dolby</b>			15. MOTHER'S MAIDEN NAME First <b>Lillian</b> Middle <b>Ross</b> Last <b>Dolby</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. Roger R. Dolby, Hurlock, Md 21643</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-19</b> , 19 <b>68</b> , to <b>1 Feb</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1 Feb</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen P. Carney</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-3-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney, M.D.</b>				22e. ADDRESS <b>Easton, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		23d. LOCATION (City or Town)		(County) (State) <b>Dor., Md</b>	
24. BURIAL DIRECTOR <b>Howard H. Willoughby</b>				25a. REC'D BY REGISTRAR <b>FEB 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03169

THE HOUSE OF DEATH

THE HOUSE OF DEATH

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>03170</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03151</div>									
1. DECEASED-NAME (Type or print) <b>LAWRENCE FRANKLIN FLUHARTY</b>					2a. DATE OF DEATH Month <b>2</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>9:47</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 21, 1910</b>		6. AGE (In years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Caroline Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Preston</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R.F.D. #2, Box 141</b>	
14. FATHER'S NAME First <b>J. Franklin</b> Middle <b>Fluharty</b> Lost					15. MOTHER'S MAIDEN NAME First <b>Bessie</b> Middle <b>Love</b> Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-14-3218</b>		17. INFORMANT Address <b>Mrs. Roberta Fluharty, Preston, Md., RFD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden myocardial infarction</b> <b>410.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5 Feb</b> , 19 <b>68</b> , to <b>5 Feb</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5 Feb</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen P. Carney</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>2-6-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney, M.D.</b>					22e. ADDRESS <b>Easton, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Preston, Maryland</b>			
24. FUNERAL DIRECTOR <b>H. J. Hampton</b> ADDRESS <b>Federalburg, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

0373

0373

EXHIBIT OF DATA

PROPERTY

PROPERTY

PROPERTY

October 11, 1910

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

03171		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03152					
1. DECEASED-NAME (Type or print) First Middle Last James Franklin Haddaway						2a. DATE OF DEATH Month Day Year 2 18 68		2b. HOUR 11:30 M			
3. SEX male		4. RACE white		5. DATE OF BIRTH January 18, 1897		6. AGE (in years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Neavitt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER —			
14. FATHER'S NAME First Middle Last William James Haddaway				15. MOTHER'S MAIDEN NAME First Middle Last Carmelia Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WWI 213-24-0303		17. INFORMANT Address Edge W. Haddaway St. Michaels, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2029 Lymphoblastic Lymphoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 2021											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. C. H. Schmidt				22c. DATE SIGNED 19 Feb 68		22d. PHYSICIAN'S NAME (Type) E. C. H. Schmidt				22e. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Neavitt Cemetery		23d. LOCATION (City or Town) (County) (State) Neavitt, Maryland		25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	

0312

UNITED STATES DEPARTMENT OF THE ARMY

0312

REPORT OF THE COMMANDER OF THE ARMY OF THE UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First <b>ADDIE</b> Middle <b>N.</b> Last <b>HIGNUTT</b>			2a. DATE OF DEATH Month <b>9</b> Day <b>68</b> Year			2b. HOUR <b>5</b> <sup>PM</sup>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>September 28, 1872</b>			6. AGE (In years last birthday) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Talbot</b> Md.					
10. CITY OR TOWN OF DEATH <b>Easton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housework</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Caroline</b>			13c. CITY OR TOWN <b>Federalsburg</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>205 Vesper Avenue</b>		
14. FATHER'S NAME First <b>John Henry</b> Middle <b>Hignutt</b> Last				15. MOTHER'S MAIDEN NAME First <b>Edna</b> Middle <b>Flowers</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Mrs. Gertie Still, Federalsburg, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4341</b> (b) <b>Coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 weeks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Atherosclerosis</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>7 Feb, 1968</b> , to <b>9 Feb, 1968</b> , that (I) (we)† saw the deceased alive on <b>Feb 9</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we)† (did) (did not) view the body after death.												
22b. SIGNATURE <b>Stephen P. Carney</b> DEGREE <b>M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-12-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney</b>		22e. ADDRESS <b>Easton, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Federalsburg, Maryland</b>					
24. FUNERAL DIRECTOR <b>Frampton Lancel Hona</b>				ADDRESS <b>Federalsburg Md</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>				

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03173

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03154

1. DECEASED-NAME (Type or print)		First <b>HARRY</b>	Middle <b>VERNON</b>	Last <b>HUTSON</b>	2a. DATE OF DEATH Month <b>February</b> Day <b>8,</b> Year <b>1968</b>		2b. HOUR <b>12:30 P.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 17, 1910</b>		6. AGE (In years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Queen Anne's Co.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot County</b>			Mo.
10. CITY OR TOWN OF DEATH <b>Bozman</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>----</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Waterman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Bozman</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>----</b>	
14. FATHER'S NAME First <b>James Henry</b> Middle <b>Hutson</b>				15. MOTHER'S MAIDEN NAME First <b>Amelia</b> Middle <b>Higdon</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-10-8974</b>		17. INFORMANT Address <b>Mrs. H. Vernon Hutson, Bozman, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109</b> <b>Acute Myocardial Infarction 15 min</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Artery, Heart, 5 yrs</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>8 Feb</b> , 19 <b>68</b> , to <b>8 Feb</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8 Feb</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Lane Wroth</b>		DEGREE <b>M. D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>R. LANE WROTH, M. D.</b>		22e. ADDRESS <b>St. Michaels, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Maryland</b>			
24. FUNERAL DIRECTOR <b>Lawson E. Leonard, St. Michael, Md</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

03174

03156

1. DECEASED-NAME (Type or print) <i>Samuel C. Jones</i>			2a. DATE OF DEATH Month <i>2</i> - Day <i>2</i> - Year <i>68</i>			2b. HOUR <i>12A</i> , M					
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>JUNE 15, 1892</i>		6. AGE (In years last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>25</i>		IF UNDER 24 HRS. HOURS <i>12</i> MIN. <i>00</i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.					
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>WATERMAN</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>SEAFOOD</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>NEAVITT</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>—</i>		
14. FATHER'S NAME First <i>GUSTAVS</i> Middle <i>JONES</i> Last <i>JONES</i>			15. MOTHER'S MAIDEN NAME First <i>EVELYN</i> Middle <i>SUTTON</i> Last <i>HUNT</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>MRS. RUTH S. JOHNSON, NEAVITT, MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>central thrombosis</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>332X</i> (b) <i>atherosclerotic cerebrovasc</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Influenza, Bronchitis, pneumonia, Embolism</i>											
19a. DATE OF OPERATION <i>8</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <i>—</i> Month <i>—</i> Day <i>—</i> Year <i>19</i> P.M. <i>—</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1953</i> , 19 <i>—</i> , to <i>2-2-68</i> , that (I) (we) last saw the deceased alive on <i>2-1-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Ray M. Beeser, MD</i>						DEGREE <i>MD</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>2-2-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Ray M. Beeser, MD</i>						22e. ADDRESS <i>St. Michael's med</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>FEB 5, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>NEAVITT CEMETERY</i>			23d. LOCATION (City or Town) (County) (State) <i>NEAVITT, MARYLAND</i>			
24. FUNERAL DIRECTOR <i>Harison E. Leonard, St. Michael's, Md</i>						25a. REC'D BY REGISTRAR DATE <i>FEB 7 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1-7-68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) First Middle Last <b>Edna Lyon Kehm</b>			2a. DATE OF DEATH Month Day Year <b>Feb. 4 68</b>			2b. HOUR <b>6:00 P.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 13, 1878</b>		6. AGE (In years last birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot</b> Md.			
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOUSE IN THE PINES</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>QUEEN ANNE'S (QUEENSTOWN)</b>		13c. CITY OR TOWN <b>QUEENSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>William H. Lyon</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>KATHERINE BREAKEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-8047</b>		17. INFORMANT <b>Niece</b> Address <b>Mrs. Ruth L. Thompson, GRASONVILLE, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-29</b> , 19 <b>68</b> , to <b>2-3</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>2-3-68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.									
22b. SIGNATURE <b>Stephen P. Carney</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>2-7-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney, M.D.</b>				22e. ADDRESS <b>P.O. Box 929, Easton, Md. 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Feb. 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westfield Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Centerville P.A. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>James D. Barton Jr. Barton Bros. Centerville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

02170  
STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1912.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1911.  
ALBANY:  
J. B. LEECH, STATE PRINTER.  
1912.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03170  
Item 6 Film G398 3/1/68 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03158

1. DECEASED-NAME (Type or print) <i>Charles E. H. Madary</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>68</i>			2b. HOUR <i>8:25</i> M	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10-22-86</i>		6. AGE (In years last birthday) <i>81</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot Eastm</i>	
10. CITY OR TOWN OF DEATH <i>Eastm</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RET</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>ST. MICHAELS</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>106 E. CHESTNUT ST.</i>		14. FATHER'S NAME First Middle Last <i>ANTHONY MADARY</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>IDA SNYDER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-03-4796</i>		17. INFORMANT <i>CHARLES R. MADARY, EASTON, MD.</i>		Address <i>Box 338</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic carcinoma of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive Pulmonary Dis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1538</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 mos</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic obstructive Pulmonary Dis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-5</i> , 19 <i>68</i> , to <i>27 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Lane Wroth</i>				22c. DATE SIGNED <i>2-28-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i> M.D.				22e. ADDRESS <i>St. Michaels, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Mar 1, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>David Ridge Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Maryland</i>	
24. FUNERAL DIRECTOR <i>James E. Leonard, St. Michaels, Ind</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03158

REPORT OF CASE

03158

1. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
2. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
3. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
4. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
5. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
6. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
7. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
8. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
9. Name of the person or persons who have been  
arrested, and the date and place of arrest.  
10. Name of the person or persons who have been  
arrested, and the date and place of arrest.

3  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-5-64  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last MARY MELVIN					Feb. Month 27 Day 1968 Year			12 25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		12-30-1879		72 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
DEL.		USA				Talbot Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton			House in the Pines			ED + TOR		NEWSPAPER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD			CAROLINE			DENTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
First Middle Last WILLIAM SHEPARD CROUSE			First Middle Last ROSETTE MOURER			16b. SOCIAL SECURITY NO.			
						17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 437.9 Chronic brain syndrome due to cerebral arteriosclerosis, manifested by aphasia and progressive cachexia									
DUE TO, OR AS A CONSEQUENCE OF (b) and progressive cachexia									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
334 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1962, to Feb. 27, 1968, that (I) (we) last saw the deceased alive on 2-14-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Trever, M.D. DEGREE					ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-27-68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
DENTON		MARCH 1, 1968		DENTON		DENTON COR. MD.			
24. FUNERAL DIRECTOR Charles Moore Denton Ind.					25a. REC'D BY REGISTRAR DATE MAR 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

03178		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03160	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Luther Herman Meredith</i>			2a. DATE OF DEATH <i>Feb</i> Month <i>19</i> Day <i>6</i> Year <i>8</i>			2b. HOUR <i>7:45</i> M	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>JUNE 20 1880</i>		6. AGE (In years last birthday) <i>87</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Albemarle Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Independent Agent</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>General Insurance</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <i>Maryland</i> COUNTY <i>Queen Anne's</i>		13c. CITY OR TOWN <i>Centreville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>111 Chesterfield Ave.</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>T.</i> Last <i>Meredith</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>-</i> Last <i>Dyott</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-32-0536</i>		17. INFORMANT <i>NIECE</i> Address <i>2511 Maple Ave., Wilmington, Del.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>486X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>493X</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic lymphatic leukemia, ASCVD, Diabetes</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>19 Feb</i> , 19 <i>68</i> , to <i>19 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>19 Feb</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carnev</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>2-20-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carnev</i>		M.D.		22e. ADDRESS <i>Easton, Maryland</i>		22f. DATE <i>2/20/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Feb. 22, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chesterfield Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Centreville, Queen Anne's, Md</i>	
24. FUNERAL DIRECTOR <i>James H. Baiter Jr. - Baiter Bros. - Centreville, Md</i>				25a. REC'D BY REGISTRAR <i>James H. Baiter Jr.</i>		25b. REGISTRAR'S SIGNATURE <i>James H. Baiter Jr.</i>	
				DATE <i>FEB 26 1968</i>			

87130

MADE IN HAWAII

MADE IN HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03179		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03161					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Ella					Mooney	Month	Day	Year	11:05 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Female		Col Negro		March 4, 1897		70 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New Jersey		USA				TALBOT Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial		Housewife		None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Talbot		Easton				20 Thoroughgood Lane			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
James Henry				Winters		Harriet				Wilson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No			216 18 8353			Mrs. Beulah Smith, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Acute left ventricular failure										5 minutes	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Arteriosclerotic heart disease										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
26 Feb 68		Bypass of Aorta			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Apr, 1965, to 29 Feb, 1968, that (I) (we) last saw the deceased alive on 29 Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)						
Stephen P. Carney		3-1-68			Stephen P. Carney M.D.						
22e. ADDRESS		22f. ADDRESS									
Easton, Maryland		Easton, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		3/5/68		Coppersville			Coppersville Talbot Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR									
BE Dashiell		426 DOVER ST. EASTON, Md.									
30M REV. 1-68		DATE MAR 5 1968									

57160

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

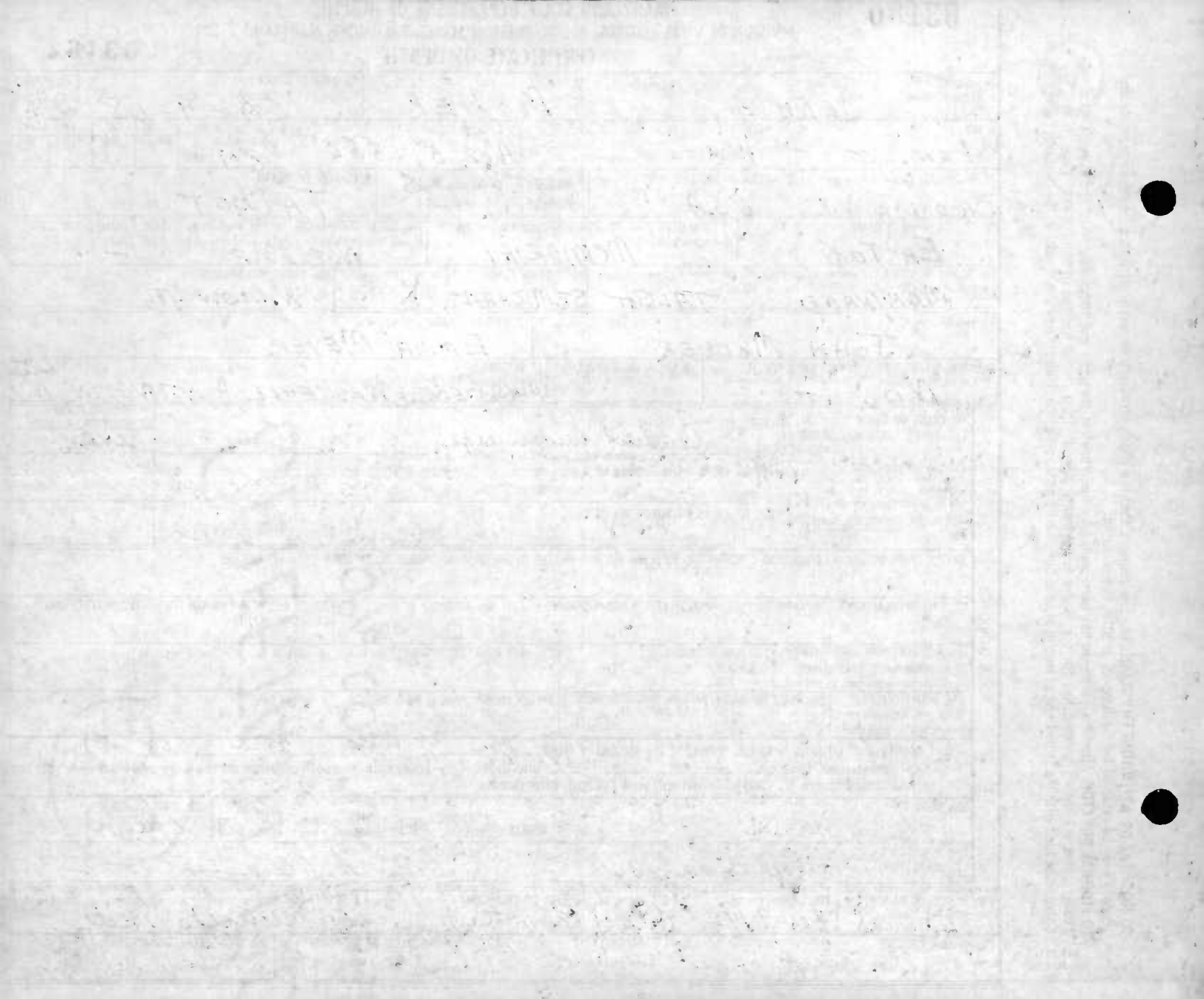
03180

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03162

1. DECEASED-NAME (Type or print) JENNIE			First	Middle	Last	2a. DATE OF DEATH Month Day Year 2-7-68			2b. HOUR 24 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Nov 5, 1880		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) BROOKLYN, N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NOT EMP			12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER WILLOW ST.			
14. FATHER'S NAME First Middle Last JOHN MOLLER			15. MOTHER'S MAIDEN NAME First Middle Last EMMA MEYER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. -		17. INFORMANT MRS. GEORGE WESTFALL		Address HUNTINGTON, N.Y. L.I.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1 pm</u> , 19 <u>68</u> , to <u>7:15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6 Feb</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thurston Harrison				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7 Feb 68			
22d. PHYSICIAN'S NAME (Type) THURSTON HARRISON				22e. ADDRESS Ct. M. Aug. 68							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) St. Michaels Md.					
24. FUNERAL DIRECTOR Harrison E. Leonard				ADDRESS St. Michaels, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Herbert W. H. Mueller</i>			First Middle Last			2a. DATE OF DEATH <i>2</i> Month <i>13</i> Day <i>1968</i> Year		2b. HOUR M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/17/1885</i>		6. AGE (In years last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.				
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>704 Dover Road</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Routeman for Ice Co.</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>704 Dover Road</i>	
14. FATHER'S NAME <i>Frederick W. Mueller</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Minnie Osterman</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>218-09-6297</i>		17. INFORMANT Address <i>Mrs. Herbert Mueller, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Under 10 min.</i> <i>1962</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4200</i> <i>None</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 6, 1962</i> , to <i>2-13, 1968</i> , that (I) (we) last saw the deceased alive on <i>11-21, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert W. Trever, M.D.</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-15-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, M.D.</i>					22e. ADDRESS <i>R D 3, Easton, Md. 21601</i>					
23a. BURIAL, CREMATION, REINTERMENT <i>Buried</i>		23b. DATE <i>2/16/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>				
24. FUNERAL DIRECTOR <i>MAURICE E. NEWMAN &amp; SON, Easton, Md.</i>					25a. REC'D BY REGISTRAR <i>FEB 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Hilda Pratt								Feb. 28 1968		10 15	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11-23-1876		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Mich.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot				Md.	
10. CITY OR TOWN OF DEATH Easton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House In The Pines		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Dor		13c. CITY OR TOWN Secretary		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Adam Newgreen		15. MOTHER'S MAIDEN NAME First Middle Last Beata Ohlson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Mrs Mark Welsh, Secretary, Md		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4341											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 5-13, 1965, to 2-28, 1968, that (I) (we) last saw the deceased alive on 2-28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen P. Carney		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-29-68					
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney		22e. ADDRESS Easton, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/5/68		23c. NAME OF CEMETERY OR CREMATORY Clare		23d. LOCATION (City or Town) Clare		(County)		(State) Mich.	
24. FUNERAL DIRECTOR Leo H. S. Thoroughly East New Market, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 7 1968		25b. REGISTRAR'S SIGNATURE Johnnie Young					

0318

RECEIVED

DATE

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TIME

RECEIVED

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03183

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03165

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First Middle Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
John Wesley SETH JR.				Month Day Year		2-10-1968 11 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	
M	C	12-8-11	56 YRS	MONTHS DAYS	HOURS MIN.	Month Day Year 19 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md		USA				TALBOT	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		MEMORIAL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		CAROLINE RD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	
JOAN		W. SETH		NO		218-16-8695	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MRS. J. W SETH, SR.		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Coronary occlusion-recurrent					
		DUE TO, OR AS A CONSEQUENCE OF (b) _____					
		DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
		HOUR A.M. P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED			
Louis J. Neely		<input type="checkbox"/>		2-11-68			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)			
WELTV		<input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		FEB 15, 1968		NEW TOWN		TALBOT MD.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Virgil Moore & Son				FEB 16 1968		Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03184

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03166

1. DECEASED-NAME (Type or print) <i>Miriam Leonette Seymour</i>		First Middle Last		2a. DATE OF DEATH <i>2</i> Month <i>15</i> Day <i>1968</i> Year		2b. HOUR M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1/29/1884</i>		6. AGE (In years last birthday) <i>84</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.	
10. CITY OR TOWN OF DEATH <i>Trappe</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Home of Mrs. and Mrs. Alex Green</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>11 Sycamore St.</i>		14. FATHER'S NAME <i>William E. Ewing</i>		15. MOTHER'S MAIDEN NAME <i>Charlotte Days</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>	
16b. SOCIAL SECURITY NO. <i>218-05-7790B</i>		17. INFORMANT <i>A. E. Seymour, Easton, Md.</i>		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senility</i> <i>4379</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							} Unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>334X</i> <i>none</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-29</i> , 19 <i>65</i> , to <i>2-15</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>2-13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Robert W. Trever, M.D.</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-19-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, MD.</i>				22e. ADDRESS <i>RFD #3 Easton, Md.</i>			
23a. BURIAL, CREMATION, REMAINS <i>buried</i>		23b. DATE <i>2/17/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>MAURICE E. NEWMAN &amp; SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>ELEANOR SHANNAHAN</b>			First Middle Last		2a. DATE OF DEATH Month Day Year <b>2-22-1968</b>			2b. HOUR <b>7:30 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8-26-1885</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.				
10. CITY OR TOWN OF DEATH <b>EASTON, MD.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOUSE IN THE PINES</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Bookkeeper Hardware</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>105 Brookletts Ave,</b>	
14. FATHER'S NAME First Middle Last <b>James Edward Shannahan</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Wrightson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>220-32-9618A</b>		17. INFORMANT Address <b>J. Graham Shannahan, Baltimore, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>443 X</b> (b) <b>Atherosclerotic and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Cardiovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days.</b> <b>Yrs.</b>										
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Fracture, RT. femur - 2 mos.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <b>5/3 60 2/22 68</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/3 1960</b> , to <b>2/22 1968</b> , that (I) (we) lost saw the deceased alive on <b>1/23 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Sheehan</b>		22c. DATE SIGNED <b>2-23-68</b>			22d. PHYSICIAN'S NAME (Type) <b>S. Kreck, JR.</b>					
22e. ADDRESS <b>Easton, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL <b>Buried</b>		23b. DATE <b>2/24/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>			23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>			
24. FUNERAL DIRECTOR <b>Maurice E. Newman</b>		ADDRESS <b>Easton, Md.</b>			25a. REC'D BY REGISTRAR <b>FEB 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

03186										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03168									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										HOUR MIN.									
Edith Mathews Smith										Feb. 29 1968										12 05 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			White			2-25-1883			85 YRS.			MONTHS DAYS HOURS MIN.																	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
West Va.			U.S.						Talbot																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Easton, Md.			House In The Pines			Homemaker																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland			Dorchester			Cambridge						701 Locust St.																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last			First Middle Last																										
Daniel H. Mathews			Lucy Charlton																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT																							
No						11612 Edwin Ave., Glenn S. Smith, Philadelphia, Pa. 19116																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>										2 weeks																			
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) <u>Aplastic anemia</u>										1 yr																			
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
2924																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			HOUR A.M. Month Day Year																										
			P.M. 19																										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION																							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> to <u>28 Feb.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
<u>Stephen O. Canby</u>										2-29-68																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			Mar. 3, 1968			Dorchester Memorial Park, Cambridge, Md.																							
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR																			
<u>Kenneth R. Thomas Jr.</u>										DATE <u>MAR 5 1968</u>																			
ADDRESS <u>Cambridge, Md.</u>										25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

03187		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03169	
1. DECEASED-NAME (Type or print) First Middle Last <i>John Swaine, Sr.</i>				2a. DATE OF DEATH Month <i>2</i> Day <i>1</i> Year <i>1968</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11/1/1889</i>	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (In years last birthday) <i>78</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Royal Oak</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pleasant Points Farm</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farming</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Royal Oak</i>	
14. FATHER'S NAME First Middle Last <i>Joe W. Swaine</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Connelia Bensinger</i>		9. COUNTY OF DEATH <i>Talbot</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-36-1805</i>		17. INFORMANT Address <i>Miss Mary C. Swaine, Royal Oak, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Cor Pulmonale</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstruct. Pulm. Emphysema</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome due to cerebral atherosclerosis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>Yrs.</i> <i>Yrs.</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <i>64/19 57 2/1 68</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/15</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>S. KRECH, JR. MD</i>		22c. DATE SIGNED <i>2/2/68</i>		22d. PHYSICIAN'S NAME (Type) <i>S. KRECH, JR.</i>	
22e. ADDRESS <i>EASTON, Md</i>					
23a. BURIAL, CREMATION, or other disposition <i>Buried</i>		23b. DATE <i>2/3/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>	
23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>					
24. FUNERAL DIRECTOR ADDRESS <i>MURICE E. NEWMAN &amp; SON, Easton, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 1-68  
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
03170									
1. DECEASED-NAME (Type or print)			First Ida Middle May Last Warner			2a. DATE OF DEATH Month Feb. Day 27, Year 1968		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 23, 1884		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.			
10. CITY OR TOWN OF DEATH Trappe		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home of Mrs. A. Green			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife, retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 310 S. Aurora St.	
14. FATHER'S NAME First William Thomas Willis Middle Last			15. MOTHER'S MAIDEN NAME First Elizabeth Ellen Roberts Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 819-07-9427		17. INFORMANT Address James Edgar Warner, Sherwood, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive cerebral arteriosclerosis</u> <u>437.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>334X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1965, to Feb. 27, 1968, that (I) (we) last saw the deceased alive on Feb. 20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-28-68	
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.				22e. ADDRESS P.O. Box 929, Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mch. 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton Talbot Md.			
24. FUNERAL DIRECTOR <u>Charles Judge</u>				ADDRESS Easton Md		25a. REC'D BY REGISTRAR DAMAR 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>James M. Warner</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR. <b>8<sup>15</sup> P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>3-30-1883</b>		6. AGE (In years last birthday) <b>84</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b>	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOUSE IN THE PINES</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Game Warden</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>303 S. Hanson St.</b>		14. FATHER'S NAME First Middle Last <b>Alfred T. Warner</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Sara Jane Fox</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-38-0003 A</b>		17. INFORMANT <b>Mrs. James M. Warner, Easton, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain hemorrhage</b> <b>485x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>68</b> , to <b>12/16</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>12/16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thorston Harrison M.D.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>13 Feb 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>THORSTON HARRISON</b>				22e. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE <b>2/15/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>	
24. FUNERAL DIRECTOR <b>Maurice E. Newman, Easton</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First MORRIS		Middle MORRIS		Last WRIGHT		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX male		4. RACE white		5. DATE OF BIRTH 12/28/1897		6. AGE (In years last birthday) 70 YRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH TALBOT					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) business man & horseman		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/> YES		13e. STREET AND NUMBER E. Central Ave.			
14. FATHER'S NAME Peter W. Wright		15. MOTHER'S MAIDEN NAME Anna Alice Hubbard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 218-36-6624		17. INFORMANT Mrs. June Nordberg		ADDRESS Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage-recurrent</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Louis Welty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2-19-68					
EXAMINER'S NAME (Type) welty		for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2/21-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION (City or Town) (County) (State) Federalsburg, Md.					
24. FUNERAL DIRECTOR Harvey Williams		ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jager					

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03173

1. DECEASED-NAME (Type or Print) <b>THOMAS</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>2 9 1968</b>			2b. HOUR <b>M</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUG 19, 1908</b>		6. AGE (In years and months) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>TALBOT</b>		
10. CITY OR TOWN OF DEATH <b>EASTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>MEMORIAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SHUL DOZER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>CAROLINE / GREENSBORO</b>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>FRANK WRIGHT</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MAE ROE</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>J. LEE WRIGHT, JR.</b>			ADDRESS <b>MILFORD, DEL.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Bundle Branch Block</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Lewis Welty</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>2-9-68</b>			
EXAMINER'S NAME (Type) <b>WELTY</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>FEB 12, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>			
24. FUNERAL DIRECTOR <b>IRVING L. MOORE</b>				ADDRESS <b>DENTON MD.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 16 1968</b>			
								25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03192				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03174			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HDUR			
THOMAS OLIN WYATT				Month 2 Day 11 Year 68				9:30 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		December 7, 1885		82 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Maryland		USA				TALBOT					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
EASTON		HOUSE IN THE PINES		Retired Night Watchman		Factory					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Caroline		Federalsburg				103 South Main Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
John Wyatt		Julia Moore		No		217-16-9427		Ruth M. Wyatt, Federalsburg, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										6 months	
IMMEDIATE CAUSE (a) <u>Vremia</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										may years	
(b) <u>Arteriosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
4500											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> ND <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HDUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Jan, 1968</u> , to <u>11 Feb, 1968</u> , that (I) (we) lost the deceased alive on <u>9 Feb, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
Stephen P. Carney		2-12-68		Stephen P. Carney, M.D.		P.O. Box 929, Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb. 14, 1968		Kingsley Cemetery		Chester, Maryland					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE					
J. J. Hampton		FEB 16 1968		Charles Judge							

